September 11th
Victim Compensation Fund

ACH PAYMENT INFORMATION FORM

This form is used for Automated Clearing House (ACH) payments for the September 11th Victim Compensation Fund. Please read the back of this form and fill in the information requested in Section 1. Then take or mail this form to your financial institution. The financial institution will verify the information in Section 1 and will complete Section 3. The completed form must then be returned ***by mail*** to the Fund at the address identified in Section 2.

SECTION 1 (TO BE COMPLETED BY PAYEE)

A NAME OF PAYEE (last, first, middle initial)	**D** TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS
ADDRESS (street, route, P.O. Box, APO/FPO) with APT/SUITE No.	**E** DEPOSITOR ACCOUNT NUMBER
CITY STATE ZIP CODE	**F** VCF CLAIM NUMBER
TELEPHONE NUMBER with AREA CODE	
B NAME OF PERSON(S) ENTITLED TO PAYMENT	[redacted]
C PAYEE'S TAX IDENTIFICATION NUMBER	

PAYEE/JOINT PAYEE CERTIFICATION		**JOINT ACCOUNT HOLDERS' CERTIFICATION** (optional)	
I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

SECTION 2 (TO BE COMPLETED BY GOVERNMENT AGENCY)

GOVERNMENT AGENCY NAME	**GOVERNMENT AGENCY ADDRESS**
US DEPARTMENT OF JUSTICE SEPTEMBER 11TH VICTIM COMPENSATION FUND	SEPTEMBER 11TH VICTIM COMPENSATION FUND PO BOX 34500 WASHINGTON, DC 20043

SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

NAME AND ADDRESS OF FINANCIAL INSTITUTION	ROUTING NUMBER ☐☐☐☐☐☐☐☐ CHECK DIGIT ☐
	DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

PLEASE MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

GOVERNMENT AGENCY COPY

PRIVACY ACT NOTICE

Collection of the information in this form is authorized by 5 U.S.C. § 552a, 31 U.S.C. § 3332(g), and Executive Order 9397 (November 22, 1943). Your social security number or tax identification number and the other information requested will allow the federal government to process your electronic payment. Your social security number is requested to ensure the accurate identification and retention of records pertaining to you and to distinguish you from other recipients of federal payments. This information will be disclosed to the Department of the Treasury and its fiscal and financial agents, and other federal agencies, as necessary to process your electronic payment. This information may also be disclosed to a court, congressional committee or another government agency as authorized or required to verify your receipt of federal payments. Although providing the requested information is voluntary, your electronic payment cannot be processed without it.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

VCF payments will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the electronic funds transfer. To effect this change, the payee will complete a new VCF ACH Payment Information Form at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is confirmed to be complete and updated in the VCF's records.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.